State of California—Health and Human Services Agency

Department of Health Services

PAS/PASARR LEVEL I SCREENING DOCUMENT

Federal Law prohibits payment for nursing facility services until PAS/PASARR screening has been done. This screening must be completed before or on the date of admission or payment cannot be made for care provided. Please complete all sections of this form that apply except for those marked FOR STATE USE ONLY.

SEE INSTRUCTIONS ON REVERSE SIDE.
SECTIONS I THROUGH VII MUST BE COMPLETED.

☐ Prescreen
☐ Status Change

Please print or type.

I. Client Data

1. Name—Last | First | Middle initial

2. Medi-Cal ID number: ☐☐☐ ☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐

3. Date of Birth: ☐☐ ☐☐ ☐☐☐☐ (M M D D Y Y Y Y)

4. Date of Last Physical Examination: ☐☐ ☐☐ ☐☐☐☐ (M M D D Y Y Y Y)

5. Primary diagnosis for admission to NF:

LEVEL I EVALUATION

II. Why Community Placement is Not an Option
(Check all that apply.)

6. ☐ Change in medical, mental, and physical functioning capability
7. ☐ Caregiver unavailable
8. ☐ Community resources unavailable
9. ☐ Client or family choice

III. Identifying Criteria for Mental Illness
(Answer yes or no to all questions.)

10. ☐ Yes ☐ No MI diagnosis (excluding dementia)
If yes, describe: _____

11. Serious difficulty within the past 3–6 months in any one of the following as a result of MI:
a. ☐ Yes ☐ No Interpersonal functioning
b. ☐ Yes ☐ No Concentration, persistence, pace
c. ☐ Yes ☐ No Adaptation to change

12. Experienced one of the following within past two years:
a. ☐ Yes ☐ No Hospitalization for psychiatric treatment
b. ☐ Yes ☐ No Serious disruption—treatment/supportive Services

13. ☐ Yes ☐ No Referred by County Mental Health

IV. Identifying Criteria for Developmental Disability
(Answer yes or no to each question.)

14. ☐ Yes ☐ No MR diagnosis: _____

15. History of MR/developmental disability?
☐ Yes ☐ No Describe: _____

16. Any presenting evidence to indicate MR?
☐ Yes ☐ No Describe: _____

17. Referred by regional center?
☐ Yes ☐ No

V. Level II Referral Data
(Referral should be mailed within five working days of evaluation.)

18. Referral date: _____

17. a. ☐ DMH referral required if number 10 shows an MI diagnosis and numbers 11–12 are ***both*** answered with at least one yes answer.
b. ☐ DDS referral required if any ***one*** of numbers 14–17 are answered yes.
c. ☐ No referral necessary.

VI. Form Completion

Form completed by: _____
Date of completion: _____
Representing facility: _____
Telephone number: _____ Extension: _____

VII. Receiving Facility

Receiving facility: _____
Address: _____
_____ ZIP code _____
Telephone number: _____ Extension _____
FAX number: _____
Admission date: _____

VIII. DMH Use Only

Override: _____
Date received: _____
Facility number: _____
County number: _____
Contractor number: _____

IX. DDS Use Only

RC name: _____
UCI: _____
Date: _____
Status: _____
Disposition: _____

X. Level II Completion

Name: _____
Title: _____
Date: _____
Determination: _____

XI. Annual Resident Review

Name: _____
Title: _____
Date: _____
Determination: _____

XII. Annual Resident Review

Name: _____
Title: _____
Date: _____
Determination: _____

XIII. Annual Resident Review

Name: _____
Title: _____
Date: _____
Determination: _____

PAS/PASARR LEVEL I INSTRUCTIONS/EXPLANATION

All information should be printed or typed. Appropriate MI/MR referral should be mailed within five (5) working days of completion of DHS 6170.

LEVEL I SCREENING CAN BE COMPLETED BY:

- Delegated Hospital Provider.
- Nursing Facility (NF)/Nursing Staff.
- Health Services Medi-Cal Nursing Staff.

LEVEL I FORM DISTRIBUTION:

- Original (White Copy) - Patient's chart.
- Yellow Copy - DMH or DDS, if applicable.
- Pink Copy - With TAR to Field Office.
- Goldenrod Copy - Facility.

PRESCREEN OR STATUS CHANGE:

- Prescreen - check if first or admission to Medi-Cal NF System.
- Status change - check if marked or significant change in resident's mental health/retardation condition. Note: Do not refer ARR to DMH/DDS.

I. CLIENT DATA

1. Beneficiary name: last, first, middle initial.
2. Enter 14-digit Medi-Cal number.
3. Date of birth: month, day, year.
4. Date of last physical: month, day, year.
5. Enter primary (main) diagnosis for admission to NF.

II. WHY COMMUNITY PLACEMENT IS NOT AN OPTION

Indicate appropriate condition that prevents placement with community resources.

III. IDENTIFYING CRITERIA FOR MENTAL ILLNESS (LEVEL II REFERRAL)

10. - 12. Please answer these questions based on the patient's current condition and the most recent history and physical. A diagnosis entered in number 10 and a yes answer in both 11 and 12 indicates a need for referral to DMH for Level II evaluation. Refer to Mental Illness "triggers" if necessary.

10. Enter any Mental Illness diagnosis, excluding dementia.

11.a. "Interpersonal functioning" Definition: inability to interact appropriately and communicate effectively with others.

11.b. "Concentration, persistence, and pace" Definition: inability to complete a simple task in a timely manner.

11.c. "Adaptation to change" Definition: typical changes in circumstances at work, school, family, or society causing exacerbation of signs and symptoms of mental illness.

12.a. "Hospitalization for psychiatric treatment" Definition: psychiatric treatment more intense than outpatient care.

12.b. "Serious disruption" Definition: episode of significant disruption which requires assistance in functioning at home or at a residential treatment setting.

IV. IDENTIFYING CRITERIA FOR DEVELOPMENTAL DISABILITY

14. - 16. Please answer these questions based on the patient's current condition and the most recent history and physical. Any Yes answer indicates a need for referral at DDS. Refer to Mental Retardation "triggers" if necessary.

V. LEVEL II REFERRAL DATA

Enter referral date and referral agency, if applicable.

VI. LEVEL I SCREEN COMPLETION

Enter name of person completing form, facility name, telephone number, and completion date.

VII. RECEIVING FACILITY

Enter nursing facility name, address, telephone number, and admission date.

VIII. - XII. FOR STATE USE ONLY